U.S. Department of Labor

Office of Administrative Law Judges
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Issue date: 22Feb2002

Case No. 2000-LHC-2020

OWCP No. 5-103118

In the Matter of

RONALD L. ELLIOTT,
Claimant
v.

NEWPORT NEWS SHIPBUILDING AND DRY DOCK COMPANY,
Employer

Appearances:
Richard B. Donaldson, Jr., Esq., for Claimant
Jonathan Walker, Esq., for Employer

Before:
Richard E. Huddleston
Administrative Law Judge

DECISION AND ORDER

This proceeding involves a claim for permanent partial disability from an injury suffered by Claimant, Ronald L. Elliott, covered by the Longshore and Harbor Workers' Compensation Act, as amended, 33 U.S.C. § 948(a). (Hereinafter "the Act"). It is undisputed that Claimant was injured when he struck his right knee on an air vent as he climbed a ladder in a tight space while employed by Employer; and that as a result he is suffering from permanent impairment of his right knee.

The claim was referred by the Director, Office of Workers' Compensation Programs to the Office of Administrative Law Judges for a formal hearing in accordance with the Act and the regulations issued thereunder. A formal hearing was held on January 11, 2001. (TR.).[1] Claimant submitted six exhibits, identified as CX 1through CX 6, which were admitted without objection (TR. at 7-8). At a later time Claimant submitted CX 7 (TR. at 26) and CX 8 (TR. at 43). Claimant's exhibits identified as CX 9 and CX 10 were withdrawn. (TR. at 46). Employer submitted nine exhibits, EX 1 through EX 9, which were admitted without objection. (TR. at 8). The record was held open for forty-five days to receive the deposition of Dr. O'Connell and his Curriculum Vitae (EX 10), along with those of other doctors who either testified or rendered opinions in this case, and an additional thirty days thereafter for briefs. (TR. at 48). The briefing schedule was extended and the record closed on June 8, 2001.

[1] EX - Employer's exhibit; CX- Claimant's exhibit; and TR. - Transcript.

The findings and conclusions which follow are based on a complete review of the record in light of the argument of the parties, applicable statutory provisions, regulations, and pertinent precedent.

ISSUE

The sole issue raised in this case is whether the Claimant is entitled to compensation for permanent partial disability to the right leg in the amount of 3% (already paid by the Employer) or to 21% claimed by the Claimant.

STIPULATIONS

At the hearing, Claimant and Employer stipulated that:

1. An employer/employee relationship existed at all relevant times;

2. The parties are subject to the jurisdiction of the Longshore & Harbor Workers' Compensation Act;

3. Claimant injured his right knee at the Newport News Shipyard on January 18, 1999;

4. That Claimant's date of maximum medical improvement was reached on February 15, 1999.

5. A timely notice of injury was given by the employee to the employer;

6. A timely claim for compensation was filed by the employee;

7. The employer filed a timely First Report of Injury with the Department of Labor and a timely Notice of Controversion;

8. That the average weekly wage was $567.27, yielding a compensation rate of $378.18;

9. That various periods of compensation had been paid for temporary total disability;

10. That a 3% permanent partial impairment rating has been paid to Claimant by Employer for this injury.

(TR. at 5-7).

DISCUSSION OF LAW AND FACTS

The following facts of this case are not disputed. (TR. at 5). As stipulated, Claimant injured his right knee on January 18, 1999. (Stipulation 3). Claimant was employed as a sand-blaster and painter

for Employer, in a capacity covered by the Act. (TR. at 10). As a sand-blaster, Claimant was required to crawl under and through tanks while pulling hoses weighing approximately 170 pounds, occasionally climb, and shovel blast grit. (TR. at 10-11). At the time Claimant injured his knee, he was working in a painting capacity. (TR. at 12). Claimant testified:

> I was working in the reactor on a carrier, and I was climbing up a vertical ladder and it's really tight in there. Everything's really tight in the reactor. And I was climbing up and there was a vent sticking out, like a fresh air vent and it had a sharp corner. When I went to bring my knee up, it struck the corner. (TR. at 12).

After his injury, Claimant was treated by Dr. Thomas Stiles. (TR. at 12). He had surgery on his knee, underwent physical therapy and reached his maximum medical improvement on February 15, 1999. (TR. at 13-14). *See also* Stipulation 4(stipulating as to Claimant's date of maximum medical improvement); (CX 1)(Dr. Stiles' office notes, medical records and work restriction slips for Claimant). At the time of his maximum medical improvement, Claimant received a permanent disability rating from Dr. Stiles. (TR. at 30).

Claimant currently works as a firefighter and medic for the City of Newport News. (TR. at 15). As part of his duties with the Fire Department, Claimant is responsible for cleaning the firehouse and his equipment. Claimant testified that he is fairly inactive as a firefighter, probably going to five fires in two years. However, if there is a fire, Claimant testified:

> ...then my duties would be to bring a hose line. And I wear a full SBA, the self-breathing apparatus with a face piece and my turnout gear. And we bring water into the fire supply to put the fire out. And fill oxygen bottles, fill the bottles for the other people. I'm on the rescue.
> (TR. at 16).

The other part of Claimant's job for the Fire Department of the City of Newport News is that of Emergency Medical Technician (EMT). As an EMT, Claimant goes to the scene of car accidents, transfers patients and attends to them medically if needed. (TR. at 17). *See also* TR. at 15-18 (describing the physical requirements of Claimant's current employment). Currently, Claimant testified that his knee gets sore after a lot of physical activity and he suffers a lot of aches and pains, especially in colder weather. (TR. at 13).

The only issue in dispute is the correct rating of Claimant's permanent partial disability, the extent of his injury. (TR. at 5). Claimant seeks compensation for a 21% permanent partial disability to his right knee based on the opinion of his treating physician, Dr. Thomas Stiles. (Claimant's Brief at 1). Employer contends that the medical evidence establishes Claimant's disability rating is no higher than 3%. (Employer Brief at 1). Employer relies on the expert opinions of Dr. Robert J. Snyder and Dr. Patrick W. O'Connell, as well a letter from Dr. James V. Luck regarding the use of the *AMA Guide to the Evaluation of Permanent Impairment* (4th Ed.) (hereinafter *AMA Guide*). (Employer Brief at 4-6).

Extent of Injury

It is the Claimant's burden to prove every aspect of his case by a preponderance of the evidence under the Act. The Act is subject to the requirements of the Administrative Procedures Act, as amended, 5 U.S.C. § 501, *et seq*., and thus the proponent of a motion or claim bears the burden of persuasion. *See Director, OWCP v. Greenwich Collieries*, 512 U.S. 267, 276, 28 BRBS 43, 47(CRT) (1994)(holding that the Act is subject to the mandates of the APA). *See also* 5 U.S.C. § 556(d), Section 7(c)(requiring that a proponent of a rule or order bears the burden of persuasion). If the evidence is equally balanced the claimant must lose. *See Greenwich Collieries*, 512 U.S. at 281, 28 BRBS at 46(vacating the "true doubt" rule and holding that a claimant must lose if the evidence is equally balanced)*; Metropolitan Stevedore Co. V. Rambo and Director, OWCP*, 31 BRBS 54, 60 (CRT)(1997)(stating that Section 7(c) of the Administrative Procedures Act applies to the Act and so the proponent of a motion bears the burden of persuasion).

In the instant case, Claimant bears the burden of proving, by a preponderance of the evidence, that his permanent partial disability rating should be 21%, the rating assigned by his treating physician. Employer disputes that rating, arguing instead that Claimant is entitled only to a 3% permanent partial disability rating, relying on two expert medical opinions and the *AMA Guide*.

In deciding what rating a claimant should receive for his permanent partial disability, this court is not bound by the *AMA Guide*. *See Mazze v. Holleran*, 9 BRBS 1053, 1055 (1978)(citing *Ortega v. Bethlehem Stell Corp*., 7 BRBS 639(1978); *Shelton v. Washington Post Co.*, 6 BRBS 54(1977); *Robinson v. Bethlehem Stell Corp*., 3 BRBS 495 (1976)); *Peterson V. Washington Metropolitan Area Transit Aurthority*, 13 BRBS 891(1981)(citing *Mazze*, 9 BRBS at 1055)). In fact, the Act does not require adherence to any particular guide or formula for measuring or rating a disability. *Mazze*, 9 BRBS at 1055. It is well established, however, that an administrative law judge is entitled to assess the credibility of all witnesses, including medical experts. *See Wenciler v. American National Red Cross*, 23 BRBS 408, 412 (1990); *Hite v. Dresser Guiberson Pumping*, 22 BRBS 87, 91 (*per curiam*) (1989)(citing *Cordero v. Triple A Machine Shop*, 580 F.2d 1331 (9th Cir. 1978), *cert. denied* 440 U.S. 911(1979); *Fyall v. Delta Marine, Inc*. 18 BRBS 241 (1986); *Todd Shipyards Corp. v. Donovan*, 300 F.2d 741 (5th Cir. 1962)); *Mazze*, 9 BRBS at 1054. In the instant case all of the medical opinions in evidence purport to rely on the *AMA Guide*, therefore, as a factor in determining the credibility and weighing those opinions their adherence to the *AMA Guide* will be considered. *See* discussion of physician opinions *infra*.

Another factor which should be considered when weighing medical evidence is whether the physician rendering an opinion is a claimant's treating physician. The Fourth Circuit has held that a treating physician is entitled to "great, though not necessarily dispositive weight." *Grigg v. Director, OWCPA*, 28 F.3d 416, 420 (4th Cir. 1994)(citing *Grizzle v. Picklands, Mather & Co.*, 994 F.2d 1093, 1097 (4th Cir. 1993) and *Hubbard v. Califano*, 582 F.2d 319, 323 (4th Cir. 1978)). The Court has been careful to state that the while opinions of treating physicians deserve special weight, they are not as a matter of law to be accorded greater weight than that of examining or reviewing physicians. *Id.* at 1097-98. *See also Milburn Colliery Co. v. Hicks*, 138 F.3d 524, 532 (4th Cir.

1998)(noting that "an ALJ should not 'mechanistically credit [], to the exclusion of all other testimony,' the testimony of an examining or treating physician solely because the doctor personally examined the claimant.")(citing *Sterling Smokeless Coal Co. v. Akers*, 131 F.3d 438, 441(4th Cir. 1997)). In fact, the Court has said that "'the testimony of a non-examining physician can be relied upon when it is consistent with the record.'" *Grizzle*, 994 F.2d at 1098(citing *Gordon v. Schweiker*, 725 F.2d 231, 235(4th Cir. 1984)). An administrative law judge must carefully scrutinize the comparative quality of medical opinions, fully consider the entire record and provide adequate reasons for crediting or discounting significant expert medical testimony. *See Milburn*, 138 F.3d at 533(explaining the duties of an administrative law judge when weighing medical evidence); *Consolidation Coal Co. v. Latusek, Director OWCP*, 187 F.3d 628, 630 (4th Cir. 1999)(unpublished)(citing *Milburn*). Although the Court has primarily dealt with the issue of the weight to be assigned to the opinion of a treating physician in the area of black lung benefits, the same general principles of weighing the evidence are applicable in all types of cases. In the instant case, Dr. Thomas Stiles is Claimant's treating physician. (TR. at 27).

Dr. Thomas Stiles

Dr. Thomas Stiles is board-certified by the American Board of Orthopaedic Surgery, a member of several professional societies, and is licensed in both Virginia and Arkansas.[2] He has been Claimant's treating physician for the injury to his right knee from January 27, 1998 to February 15, 1999. (TR. at 27). Dr. Stiles believes that being a treating physician gives a doctor an advantage when assigning a rating of disability to a patient. He testified:

> [Y]ou have the advantage of having seen how the patient reacted to surgery, and have the advantage of having seen what was inside the joint when you actually looked in there. And you have the advantage of seeing how this has affected them over numerous visits. (TR. at 32).

Claimant selected Dr. Stiles as his physician, despite the fact that he was not on the list of doctors Employer gave him to choose from. (TR. at 41). Claimant testified that he chose Dr. Stiles because he had heard that Dr. Stiles "did a good job, as far as knee surgeries go." (TR. at 41).

During his treatment of Claimant, Dr. Stiles ordered x-rays and an MRI of Claimant's knee and performed arthroscopic surgery on March 26, 1998. (TR. at 27). *See also* (CX 1-2,8)(ordering x-rays for Claimant);(CX 1-12)(operative note from Claimant's surgery). Dr. Stiles stated that the purpose for Claimant's surgery was the persistence of his pain after injury. (TR. at 27). During that surgery, Dr. Stiles found that Claimant had torn his lateral meniscus, or cartilage. *Id.* Regarding the surgery, Dr. Stiles testified:

> [T]he meniscus that we took out that was torn is a stabilizer in the knee. It acts to make a round object fit onto a flat surface, so it stabilizes those two surfaces. Once you take it out, then you destroy some of the stability of the knee. You also change the

[2] Dr. Stiles' Curriculum Vitae was admitted into evidence and submitted post-hearing as CX 7. (TR. at 26).

> weight-bearing structure of the knee because it bears a certain amount of the weight and distributes it all around the knee. Now you concentrate the weight-bearing in a tighter area and make the joint a little bit unstable and change the weight-bearing, so it's prone then to degenerative processes as a result of the change in the weight-bearing. ...[In time, patients] get increasing amounts of difficulty with the knee. The cartilage, because of the altered weight-bearing status, wears out, cracks, splits, comes apart, and they get what's called a post-traumatic arthritis in their knee. ... Makes [the knee] much more symptomatic, becomes painful and more and more unstable. Even of a giving way, catching, recurrent swelling. (TR. at 28-29).

According to Dr. Stiles, this condition is a fairly common result of the type of injury suffered by Claimant combined with the surgery that he underwent. (TR. at 29). Despite this testimony as to the probable future condition of Claimant's knee, Dr. Stiles testified that his opinion was based on the knee's present condition. (TR. at 33-34).

After studying Claimant's x-rays, his MRI, and having more follow-up visits with him, Dr. Stiles concluded that, as of his date of maximum medical improvement, Claimant had a disability rating of 20%. Dr. Stiles later adjusted that rating to 21%. (TR. at 30)(CX 1-27). On February 15, 1999, Claimant's date of maximum medical improvement, Dr. Stiles noted that Claimant was still reporting pain occasionally, and that his "quads are returning nicely but he still has occasional giving way." Dr. Stiles then states:

> On examination today [Claimant] has a good range of motion without an effusion. His x-rays from the [Employer] were measured. He has a 3 millimeter cartilaginous space, patella femoral, and a 2 millimeter tibial femoral in his lateral compartment.
>
> It is my opinion that he has a permanent disability in his right knee according to the AMA guidelines of 20% of his right lower extremity. It is my opinion this will not improve in the future.... (CX 1-26).

Dr. Stiles later adjusted Claimant's impairment rating to 21% because he included "the lack of his meniscus or cartilage, as well as his narrowing of his joint space." (TR. at 30-31). It is this type of combination that Dr. James V. Luck[3] disagrees with. *See* discussion *infra*. *See also* (EX 9)(explaining Dr. Luck's position). Specifically discussing his rating of Claimant, Dr. Stiles testified:

> [T]he 21% was rated as far as his loss of his cartilage space in the lateral compartment of his knee joint and what he's lost in his lateral meniscus. The cartilage space was

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[3] Dr. Stiles testified that Dr. Luck is:

> an orthopaedist in California. He's probably chairman of one of the departments there, I'm not sure exactly where. But he's a contributor to the *AMA Guide* and he's chairman, I think, of the orthopaedic department of the *AMA Guide*. (TR. at 34). No other evidence of Dr. Luck's qualifications and credentials was submitted by Employer.

> measured at, I believe, three millimeters and according to AMA [Guide] tables, that should give him a twenty percent [20%] disability. The lack of his cartilage gives him a one percent. (TR. at 32-33).

Dr. Stiles stated that, generally, when he is providing a rating for the purposes of worker's compensation he considers:

> ...the problem that the patient has, how much it's going to bother them, the amount of actual disability that the *AMA Guide* gives to them or the *AMA Guide* as far as impairment is considered. (TR. at 31).

Dr. Stiles testified that he always uses the *AMA Guide* as a part of making an impairment decision, "particularly in shipyard injuries because [Employer] require[s] that the *AMA Guide* be used. ... I don't always think the *AMA Guide* are exactly what I would give the patient, sometimes a little more, a little less. But usually it is pretty close." (TR. at 31-32).

After reviewing the reports of the other medical experts in this case, Dr. Stiles stated that he still believed that his rating of 21% impairment was appropriate, to "a reasonable degree of orthopaedic surgery [sic– certainty]." (TR. at 37). The bulk of that rating is due to Dr. Stiles' three millimeter measurement of Claimant's cartilage space and the corresponding 20% rating given to that measurement in the *AMA Guide*.

Specifically discussing his formulation of a disability rating in this case, Dr. Stiles' explained how he measured Claimant's x-rays in a post-hearing deposition.[4] Claimant had three x-rays taken at the shipyard clinic and dated February 15, 1999. (Stiles' Depo. at 6). The x-rays were marked and submitted as exhibits to both Dr. Stiles' deposition and the deposition of Dr. O'Connell. *Id.* at 9. *See also* (EX10b at 26). The measurements of cartilage space were made on these x-rays and the corresponding ratings for those different measurements in the *AMA Guide* are the reason for the vast difference between the medical experts' ratings. Therefore, in order to understand the differences in the opinions, a discussion of how those measurements were made is required.

The first x-ray Dr. Stiles analyzed was the standing, or AP, x-ray, designated as "AP-1 with a circle around the 1." (Stiles' Depo at 4). This x-ray is taken from front to back with the patient standing. Dr. Stiles measured the lateral compartment cartilage and space. As best he can remember his measurement was two millimeters. *Id.* Dr. Stiles measured between the superior portion of the space and the inferior portion of the space. He stated that, in his opinion to a reasonable degree of medical probability, this is the appropriate location to conduct the measurement on this type of x-ray. *Id.* Dr. Stiles stated that his measurements go from middle to middle of the curve in order to measure the space, not the front to back. *Id.* at 7. When asked, Dr. Stiles testified that he was not sure that you could see the front of the curve in the x-ray and stated that it was not his testimony that the back of the curve could be seen on this x-ray. *Id.* at 8. Dr. Stiles was not there when the x-ray was taken so he

[4] This deposition was taken April 2, 2001 and will hereinafter be identified as "Stiles' Depo."

does not know how it was taken. *Id.* at 9. The following exchange concerning this x-ray occurred:

> Q: You do agree that if the x-ray is not taken dead on that you will then see a sloping angle above the [inferior surface]?... In other words, this is not taken dead on, this is a little bit low; is that correct?
>
> A: I don't know how it was taken. I was not there when it was taken. ...No [I can not tell from looking at the x-ray].
>
> Q: Why do we then see a portion of the inferior surface and not the superior surface?
>
> A: I don't know.
> (Stiles' Depo. at 8-9).

The second x-ray Dr. Stiles discussed is marked "Lat" with a "2 circled," and is taken from side to side. (Stiles' Depo. at 5). Dr. Stiles stated that Dr. O'Connell measured a space that he doesn't usually use this view to measure, the medial compartment. He marked a space "which is, in my opinion, the lateral compartment and would be the proper area to measure the cartilage and space, since the lateral compartment is the one that we're dealing with." *Id.*

Finally, Dr. Stiles discussed the Sunrise view, marked "Sunrise" with a "3 circled." (Stiles' Depo. at 5). Dr. Stiles did not use this x-ray or this space for marking Claimant's disability. *Id.* at 5-6. Dr. Stiles disagrees with the markings Dr. O'Connell made to measure Claimant's disability on both the Lateral view x-ray, marked with a 2, and the AP x-ray, marked 1. He does not disagree with his measurements on the Sunrise view, marked 3. *Id.* at 7. Although Dr. Stiles has been Claimant's treating physician and asserts the importance of such status to making an impairment rating, when asked the basis of his ratings he does not include any of the factors he discussed as advantages to being a treating physician, such as personal observations. Instead, Dr. Stiles states that he relied on the *AMA Guide*, the measurements he took off the x-rays, and ultimately "the lack of his meniscus or cartilage, as well as his narrowing of his joint space." (TR. at 30-31). As Dr. Stiles acknowledges, these measurements are objective and do not require subjective judgment on the part of the physician. (CX 1-29). As the personal observations or long-standing treatment which would entitle a treating physician's opinion to greater weight are not relied upon-or even considered- by Dr. Stiles in formulating his opinion, his status as treating physician does not entitle his opinion to greater weight in this case.

Dr. Robert J. Snyder

Claimant was also examined by Dr. Robert J. Snyder,[5] of Orthopaedic Surgery and Sports Medicine Center, on July 6, 1999. (EX 7). After the Department of Labor recommended Claimant

[5] Although Dr. Snyder's Curriculum Vitae was not available to this court, I note that Dr. Snyder is a board-certified orthopaedic surgeon according to the American Board of Medical Specialties Who's Certified? Website. *See* << http://www.abms.org/newsearch.asp>> .

get a second opinion as to the degree of permanent partial disability sustained, Employer and Claimant, after some debate, chose Dr. Snyder from a list of candidates. (EX 1-3)(CX 2, 4). On July 6, 1999, Dr. Snyder examined Claimant. After that examination Dr. Snyder wrote the following report:

> Examination of the patient's right knee shows him to have still 1 cm of quadriceps atrophy compared to the left knee measuring the thigh one hands breath above the patella. The patient has full motion from 0-120 degrees of the right knee. There is no instability to medial or lateral stress testing, nor is there any evidence of abnormal anterior drawer, not is there any abnormal Lachman. The patient has no effusion.
>
> X-rays were taken of both knees. X-rays are remarkable only for the fact that they show no evidence of arthroses or arthritic changes. In fact in comparison of the left knee to the right knee shows no differences on any of the x-ray views. (EX 7-1).
>
> At this point it is my opinion that the patient can work full activities including heavy activities without any limitations whatsoever as far as the ability to climb or lift heavy materials. The assignment of a permanent disability rating can be based upon many methods. Applying the Guides to the Evaluation of Permanent Impairment fourth edition to this patient would result in a 1% whole person impairment rating and a 3% lower extremity rating. The second method to assign a disability rating to this patient would be on the basis of his diagnosis. The patient underwent a partial lateral meniscectomy and utilizing the appropriate table No. 64 would result in a 1% whole person rating or a 2% lower extremity rating under this method. Thus to give the patient the benefit of the doubt, I would rate an impairment rating on the basis of his quadriceps atrophy only and a final disability rating would thus be 1% whole person impairment or 3% of the lower extremity. (EX 7-2).

As Dr. Stiles noted when comparing his rating with that of Dr. Snyder, the difference in their report is that Dr. Snyder does not combine the disability ratings for the loss of meniscus and post-traumatic arthritis in his joint. (TR. at 33). Thus, Dr. Snyder used the largest disability rating he found warranted, a rating based on Claimant's quadriceps atrophy. (EX 7-2). It is clear from Dr. Snyder's report that a rating strictly on the loss of meniscus would only give Claimant a rating of one percent. (EX 7-2). Although Dr. Snyder does not specify his measurements, it is clear that none of the measurements he arrived at resulted in a rating greater than 3%. (EX 7-1,2). As discussed *supra*, Dr. Stiles measured Claimant's cartilage space at 3 millimeters, thus apparently indicating arthritis in the knee (CX 1-26), while Dr. Snyder noted "no evidence of arthroses or arthritic changes" and no significant differences between the left and right knee x-rays. (EX 7-1).

Dr. Patrick W. O'Connell

Patrick W. O'Connell, M.D., of Atlantic Orthopaedic Specialists, is a board-certified orthopaedic surgeon.[6] Dr. O'Connell gave a deposition on February 5, 2001 which was accepted into

[6] *See also* EX10a (Dr. O'Connell's Curriculum Vitae referenced within the deposition as an exhibit).

evidence at EX10b. *See also* (EX10a)(Dr. O'Connell's Curriculum Vitae referenced within the deposition as an exhibit). At the request of Employer, Dr. O'Connell evaluated Claimant and assigned him a two percent diagnosis-related impairment rating based on the *AMA Guide*. (EX 10b at 15-16). Dr. O'Connell used the *AMA Guide* because, according to the American Academy of Orthopaedic Surgeons, it is the standard for evaluating impairment. *Id.* The purpose in developing the *AMA Guide* was to make impairment ratings more standardized, to make it much more objective and less subjective. *Id.* at 17. *See also* (CX 1-29) (Dr. Stiles discussion of the objective purpose and nature of the *AMA Guide*).

Dr. O'Connell used Claimant's diagnosis-related impairment rating because, according to the *AMA Guide*s, it resulted in Claimant's greatest impairment rating. As Dr. O'Connell explained:

> The fact that [Claimant] had had the surgery and had been noted to have a meniscus tear at the time of arthroscopy [were considered in this impairment rating]. Utilizing the guides based on a radiographic evaluation would result in a zero impairment. Using the guides based on functional evaluation would result in a zero impairment. Using the diagnosis-related section gave him his greatest impairment at two percent. (EX10b at 18-19).

Dr. O'Connell stated, in a two-page report, that his impairment rating of Claimant was based on Claimant's medical history, a personal interview with and examination of Claimant, and reviewing Claimant's radiographs and MRI. *Id.* at 19.

At his deposition, Dr. O'Connell stated that he has no independent recollection of Claimant, nor does he remember how long he spent with Claimant in performing his examination. (EX10b at 19-20). Relying on his office notes from his examination of Claimant, Dr. O'Connell testified:

> To my examination pertinent to his regular right lower extremity, there was a normal alignment of the extremity. He had a normal gait. He had a – what we would rate as a trace to one plus effusion in the knee. That is, a small bit of fluid in the knee. There was a full range of motion, which was approximately zero to a hundred and forty-five degrees and equal to his other side. There was some thickening in the soft tissue over the medial plica, which is just sort of inside where the kneecap is. And there was tenderness to palpation in that area. There was no tenderness a[l]ong the joint line, no negative McMurray's, which is a test for meniscus tear. There was no significant crepitus or grinding noted in the patellofemoral joint, meaning the back side of the kneecap and the front of the femur. There was no instability of looseness noted in the knee. *Id.* at 7-8.

He further testified that he found no atrophy in the knee or the quadriceps, stating "[Claimant] had good quadriceps tone and girth, so he did not have any significant atrophy in his musculature." *Id.* at 8. Dr. O'Connell later indicated that, as a matter of routine, he measures patients' quadricep tone and girth during examinations and so he is certain that he did so when examining Claimant, although there is no

exact measurement noted in Claimant's file. *Id.* at 21. He testified that he only makes a note of the exact measurements if there is a significant difference. He stated:

> If there's not a difference, I decide that I oftentimes won't make a note of it. The exact measurement, in my evaluation, isn't as important as a different side-to-side difference, as there is a wide variety as far as the girth of the quadriceps in the basic population. (EX10b at 21).

Dr. O'Connell also reviewed Claimant's three x-rays during his deposition and explained how he made his measurements. The first x-ray Dr. O'Connell reviewed was the AP view. (EX 10b at 10). Dr. O'Connell states:

> ...what you're looking at is the distance between the joint surfaces. Now ...ideally you'd get an x-ray straight through, but you can basically tell where the joint surface is by where the line of sclerosisis right here [the brightest point on the lower right-hand side of the joint space]. ... So the true joint space you'd measure from the bottom of the condyle here to that line of sclerosis. And so that would be approximately seven and a half millimeters. ... This is the medial joint space. And above that what you see back here is the posterior tibial plateau just going backwards, so it's just a – you know, if you have a joint space, and the x-ray shoots perfectly perpendicular to it, you will see that space, but if you're tangential at all, you will get some of the bone above and below that's coming up there. [Which would essentially be the middle and the back of that bone]. *Id.* at 9-10.

Dr. O'Connell went on to testify that cartilage space should not be measured there as it would not be an accurate measurement of that space because it would "essentially be the middle and back of that bone." *Id.* at 10.

The next x-ray Dr. O'Connell looked at is called the lateral side. Again, Dr. O'Connell states that the x-ray is not as clear or in the exact position it should be in. (EX10b at 10-11). He states that measuring in the lateral joint space is not how "we" usually do it, but in this case "if you measure in this lateral joint – on the lateral view, it's measuring about seven millimeters right there." *Id.* According to Dr. O'Connell, measuring on either the lateral view or the lateral side, neither are even close to three millimeters. Only if you measure in a space that is not the joint space could you get three millimeters. Three millimeters, in Dr. O'Connell's medical opinion is not correct. *Id.*

Dr. O'Connell goes on to state:

> [It is] fairly easy to tell based on this x-ray that there really is no significant arthritic change seen at all, and you can see there's nothing that looks like three millimeters there. And this – where the bone goes up here is in the middle of the knee where the tibial spine is, but on the joint surface you can see the distance from the femoral condyle down to about here, which looks normal. So, no, I don't see anything that looks like

three millimeters. *Id.* at 11-12.

Next Dr. O'Connell looks to the third x-ray, the sunrise view to measure the patellofemoral space. Dr. O'Connell states that that space is about four and a half millimeters. The measurement and space is directly in the middle of "the trochlear groove, which is the front of the femur–the groove in the front of the femur where the patella tracks up and down." *Id.* at 12. Regarding this space, the following exchange occurred:

> Q: Is there any aspect of that space that in your medical judgment could be seen as less than–two millimeters or less?
>
> A: No. No. That's a fairly – that's a very normal looking patellofemoral joint space. I don't really see any significant narrowing there at all. [It's probably measuring about four point five millimeters.].
> (EX10b at 13).

Dr. O'Connell also stated that the physician's subjective judgment is not necessary in measuring atrophy, giving a diagnosis-based estimate, or in giving an arthritis-based estimate. (EX10b at 24). Range of motion is also a "very objective measurement." *Id.* at 24-25. Dr. O'Connell based his opinion and his impairment rating to Claimant's knee on objective criteria. In fact, he based his opinion on the radiographic evidence, his measurements, and the *AMA Guide*s. These are the same factors Dr. Stiles states that he relied on in assigning an impairment rating. Because these measurements, and therefore ratings, are based on objective criteria that anyone could judge from the radiographic evidence, a superior knowledge of Claimant's history and condition are not necessary in making the measurements or assigning a rating. Therefore, Dr. O'Connell's opinion is entitled to the same amount of weight as Dr. Stiles' opinion.

Dr. James Luck

A great deal of emphasis in this case has been placed on the *AMA Guide* and the proper way to measure Claimant's x-rays. Another issue is the combination of Claimant's narrowing of joint space and his meniscectomy, or diagnosis-related rating. According to Dr. James V. Luck, a board-certified orthopaedic surgeon[7] who was involved in writing pertinent sections of the *AMA Guide*,[8] these ratings should not be combined. (EX 9). Although an adherence to the *AMA Guide* is not mandated, as discussed *supra*, all of the doctors who have rendered opinions in this case state that they relied on these guidelines in reaching their opinions. Therefore, a correct application of these guidelines lends weight and credibility to an opinion.

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[7] Although Dr. Luck's Curriculum Vitae was not available to this court, I note that Dr. Luck is a board-certified orthopaedic surgeon according to the American Board of Medical Specialties Who's Certified? Website. *See* << http://www.abms.org/newsearch.asp>> .

[8] Again, the court relies on Dr. Stiles testimony as to this fact, as Dr. Luck's Curriculum Vitae was not available. (TR. at 34).

In a letter dated November 3, 2000, Dr. James Luck responds to an inquiry from Employer as to the use of Table 62 in the *AMA Guide*s. (EX 9). As Dr. Luck understood the issue he was addressing related to a patient with multiple degenerative changes in his knee involving more than one compartment. Dr. Luck explains that the intent of the Guide authors (including himself) was that "patients be rated based on the most severely involved compartment that would give the highest rating." (EX 9).

He further explains:

> Patients with meniscal pathology who have had partial or total meniscectomies as well as narrowing of the joint space of the knee would be rated for one or the other, but not for both. Therefore, a patient who had had a partial medial meniscectomy and had narrowing of the medial compartment would be rated for either narrowing of the medial compartment or the partial meniscectomy, whichever gave the higher rating which would most probably be the medial compartment narrowing. (EX 9).

According to Dr. Luck the reasoning for this policy is that "patients' symptoms and need for medical and surgical intervention relate to the narrowest compartment, principally medial or lateral, and are not worsened by having another compartment narrowed as well." (EX 9).

When applying this explanation to Dr. Stiles' opinion, it seems Claimant's 20% rating was based on the compartment narrowing and the partial meniscectomy was rated at 1%. *See* (CX 1-29). Although Dr. Luck states that these ratings should not be combined, Dr. Stiles commented that this surprised him because:

> The recent guidelines that have come out, the fifth edition, specifically states that you can combine the degenerative arthritis with specific entities, such as the loss of the meniscus. I disagree with him as far as the two compartments is concerned, but it really is not important in this case because we only considered one compartment in his knee anyway. (TR. at 34-35).

While the combination of ratings appears to be a confused issue for users of the *AMA Guide*, in this case the true controversy is the measurement of the cartilage space on the three x-rays taken by Employer.

Dr. Stiles is the only person who measures Claimant's cartilage space at three millimeters, or in fact, anywhere near an abnormal measurement. (TR. 35-36). Although Dr. Stiles is Claimant's treating physician, because he bases his opinion on the purely objective measurements and ratings of the *AMA Guide* his opinion is not credited with greater weight than that of the other experts in the case. *See* (CX 1-28, 29)(Dr. Stiles discussing the objectivity of the *AMA Guide*s and his use of them in this case);(CX 1-26, 32, 33)(Dr. Stiles explaining the basis of his rating of Claimant); (TR. at 32-33)(Dr. Stiles testimony explaining his impairment rating of Claimant). *See generally,* Stiles' Depo.(explaining how Dr. Stiles made the measurements on which he relied in rating Claimant's impairment). As Dr.

Stiles opinion is not entitled to greater weight, I find that, at the very least, the evidence in this case is in equipoise. As the Court stated in *Greenwich Colliers*, if the evidence in equipoise the party bearing the burden, in this case Claimant, must lose. 512 U.S. at 281, 28 BRBS at 46(vacating the "true doubt" rule and holding that a claimant must lose if the evidence is equally balanced). Further, I find that the explanation of Dr. O'Connell of the poor quality of the x-rays on which both he and Dr. Stiles based their opinion upon credible. Dr. Stiles does not seem to dispute this point, merely stating that he was not there when the x-rays were taken. The only doctor with new x-rays of Claimant's injured knee, in addition to x-rays of his non-injured knee for comparison, was the independent doctor who reviewed this case, Dr. Snyder. His succinct explanation of the condition of Claimant's right knee and subsequent rating of that knee was credible, and therefore I credit his rating of 3% impairment.

Upon consideration of the entire record before me, therefore, I find that Claimant has not carried his burden of proof by a preponderance of the evidence to establish a disability rating of 21%. Therefore, Claimant is entitled to a 3% permanent partial disability rating for which he has already been compensated.

Order

Accordingly, it is hereby ordered that:

1. While the Claimant, Ronald Elliot, is entitled to compensation for a 3% permanent partial disability to the lower extremity at the compensation rate of $378.18, he has not established entitlement to a greater rate of compensation;

2. Employer, Newport News Shipbuilding and Dry Dock Company, shall receive credit for the 3% compensation already paid;

3. As compensation above the rate of 3%, which was accepted and paid by the Employer, has not been awarded, Claimant's attorney is not entitled to an attorney's fee for services rendered in this proceeding.

A
Richard E. Huddleston
Administrative Law Judge